Developmental Disabilities in Adults

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The term ‘developmental disability’ (DD) refers to the definition given in the US Developmental Disabilities Assistance and Bill of Rights Act (2000) and is a broad concept covering the equivalent terms of learning disability, mental retardation, and intellectual disability commonly used in the United Kingdom, North America and Australia respectively. In general terms DD means a severe, chronic disability of an individual that: (a) is attributable to a mental or physical impairment or combination of both; (b) is manifested before 22 years of age; (c) is likely to continue indefinitely; and (d) results in substantial functional limitations in three or more areas of major life activity. In addition to intellectual disability, the concept includes other conditions that do not necessarily involve significant sub-average intellectual functioning such as autism and epilepsy. The definition of DD also focuses on a person’s life-long need for individually planned supports and assistance. For these reasons, it is an appropriate term to describe the population served by specialist disability forensic services in the UK and other parts of the world.

Historically, DD has been viewed as a key determinant of offending behaviour. Commentators from the nineteenth century onwards have suggested a causal association between low intelligence and criminality. There is robust evidence supporting a relationship between intellectual functioning (IQ) and offending, with those with lower IQs showing greater rates of offending than those in higher functioning groups. This relationship appears to hold even when socio-economic status is controlled for. However, most of the research in this area has involved participants with IQ scores ranging from low average to high average (80 to 120 IQ points). Studies that have included participants

with significantly low IQs (less than 80 IQ points) have found that offending rates for this group are lower than those in the low average group (81 to 90 IQ points). Thus, it would appear that when studies are extended to include participants with IQs below 80 the relationship between intellectual functioning and offending is not simple and linear.

Studies in the UK on the prevalence of offending by people with DD yield different rates depending on the location of the study sample: community DD services, 2%-5%; police stations, 0.5%-8.6%; prisons (remand), 0%-5%; and prisons (convicted), 0.4%-0.8%. In addition to study location resulting in sampling bias and filtering effects, other sources of variation of prevalence of offending reported across studies include inclusion criteria used (particularly if people with borderline intellectual functioning are included or not), and the method used to detect DD (e.g. IQ test vs. clinical interview). The countries in which prevalence studies are conducted can affect reported rates considerably, probably due in large part to the different social and criminal justice policies that are applied. For example, studies of the prevalence of convicted prisoners with DD in prisons in England have reported rates of up to 5%, compared with just under 10% in the US, and over 28% in Eire. Therefore, despite the long association between intellectual functioning and criminality, and in the absence of well designed studies comparing the prevalence of offending in populations of people with DD with those for non-DD populations, it is not clear that people with DD commit more crime than those without DD. Similarly, there is no good evidence to show that the frequency and nature of offending by people with DD differs from that committed by offenders in the general population.

Follow-up studies of offenders with DD have reported recidivism rates of up to 72%. However, as for prevalence studies of offending by people with DD, reported recidivism rates vary a great deal for many of the same reasons including study methods and procedures, research settings and the definition of recidivism used. Recent research in the US on 252 offenders with DD subject to a case management community programme found that 25% of programme completers were re-arrested within six months of finishing the programme, compared with 43% of those who dropped out of the programme. There is a dearth of controlled studies comparing recidivism rates for offenders with DD and non-ID offenders, but in another US study 43% of 79,000 general offenders on probation were re-arrested. Based on the limited data available to date it is not clear that recidivism rates for offenders with DD and those for general offenders are very different.

The evidence for the effectiveness of interventions for offending by people with DD is quite limited but has been building steadily over recent years. The treatment of anger and aggression for offenders with DD using cognitive-behavioural therapy approaches is best developed with a number of small controlled studies showing good outcomes for treatment over wait-list control conditions for participants treated in both community and secure hospital settings. This is an important development as research conducted across three continents, using broadly similar methods, has shown that aggression is a serious issue in the DD population and is the main reason for people with DD being admitted (and re-admitted) to institutions, and the primary reason for the prescription of behaviour control groups in this population.

There are no controlled trials of treatment for sex offenders with DD, mainly due to ethical issues in denying potentially beneficial interventions to those presenting serious risks to others. In a recent review of 19 studies of treatment effectiveness for sex offenders with DD, the authors concluded that the outcomes for psychological interventions appear to be marginally superior to those for drug therapy and service/management interventions. The evidence available, whilst based on small-scale methodologically weak studies that have yielded variable outcomes, indicates that attitudes towards and cognitions concerning sexual offending can be improved. There is some limited evidence that mandated and longer interventions result in lower levels of sexual re-offending in this population.

The research evidence supporting interventions for fire-setters with DD is even more limited. There has been one case study, two small case series and one pre-post intervention outcome study that have provided some encouragement that broadly cognitive-behavioural group based interventions can help with fire interest and attitudes and emotional problems associated with previous fire-setting behaviour in these clients.

There have been some advances recently in the development and modification of measures designed to assess the risk of violence and sexual aggression in offenders with DD. Established risk measures such as the Violence Risk Appraisal Guide, HCR-20 and Static-99 have been shown to have good reliability and validity when used with DD offenders in high, medium and low secure and community settings. Further work has shown that the severity of assessed personality disorder (including psychopathy) in offenders with DD is positively associated with measures of risk of future violence and sexual aggression.

The policy of de-institutionalisation has resulted in significant changes in the design and delivery of services for offenders with DD in recent years. Against this background the evidence to support the use of assessment tools and interventions for these clients has been building gradually from a very low baseline. It is not clear if people with DD are over-represented in the offender population, or whether offending is more prevalent among people with DD compared with the general population. However, there is some limited evidence available to guide clinical services and practitioners in developing cognitive-behavioural interventions for people with DD who are angry and violent, sexually aggressive or who set fires. There has also been some progress in the development of dynamic and actuarial risk assessments to help evaluate clients' progress in therapy and rehabilitation. While there are difficulties in interpreting the findings of recidivism studies involving offenders with DD, early indications are that, as for non-DD offenders, mandated and longer-term interventions result in better outcomes than voluntary and shorter treatments. Further research with this population is required to build on the limited evidence available to improve and knowledge and future practice.

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